

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Arcadia Care Aledo		STREET ADDRESS, CITY, STATE, ZIP CODE 304 S.W. 12th Street Aledo, IL 61231	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. The facility face sheet shows R5 was admitted to the facility with diagnoses to include cerebral infarction, hypertension and alcohol dependence. R5's facility assessment dated [DATE] shows him to be cognitively intact with no behaviors and requires standby assistance from staff for mobility. A nursing progress note dated 6/24/2025 shows R5 was in an incident with another resident.</p> <p>On 7/2/2025 at 12:30 PM, R5 said he was walking to his room from lunch and R6 came up to him and accused him of stealing his shirt and underwear. R5 said R6 hit him on his arm and continued yelling at him. R5 said a staff member came up to the situation right away and he was not physically harmed by R6.</p> <p>On 7/2/2025 at 1:24 PM, R6 said he does not remember the incident.</p> <p>On 7/2/2025 at 12:55 PM, V5 Certified Nursing Assistant (CNA) said she was helping another resident to the toilet when she heard yelling in the halls. V5 said she ran to the yelling and saw R6 hit R5 in the arm and R6 was yelling at R5 saying he had stolen his shirts and underwear. V5 said she quickly separated the residents and had R5 return to his room and she stayed with R6 trying to calm him down.</p> <p>The undated facility abuse investigation report shows on 6/24/2025 at approximately 6:30 PM, R5 was allegedly involved in a physical altercation with a peer.</p> <p>The facility investigation shows an interview with R6 showing he thought R5 took his underwear and he got upset. R6 said he has memory problems and feels bad. R5's statement to the facility showed R6 thought his underwear were stolen and accused R5 of taking them.</p> <p>The facility face sheet for R6 shows he was admitted to the facility with diagnoses to include left leg fracture, cerebral infarction and post traumatic stress disorder. R6's facility assessment dated [DATE] shows him to be cognitively intact and uses a walker and wheelchair for his ambulation. Nursing progress notes for R6 shows since the altercaton with R5, his behaviors have been escalating, he was arrested for a staff assault, went to jail and is currently back at the facility under the care of a psychiatrist and one to one observations.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. The facility face sheet for R4 shows he was admitted to the facility with diagnoses to include cerebral infarction, migraine, and for palliative care. The facility assessment dated [DATE] for R4 shows him to have moderate cognitive impairment and is dependent on staff for his care. The nursing progress notes for R4 shows he was admitted to the facility on [DATE], was found on his knees in his room on 6/6/25 and on 6/7/25 the nurse documented R4 had fallen and a mechanical lift was used to lift him from the floor at 1 AM. The same nurse V3 Registered Nurse (RN) documented the resident was on a one to one observation for behaviors and making attempts to get on the floor through out the night.</p> <p>On 7/2/2025 at 9:45 AM, R4 said he has no concerns with his transfers in the facility.</p> <p>On 7/2/2025 at 10:32 AM, V4 Housekeeper said on Saturday 6/7/2025 around 5:30 AM, she had just come to work and heard yelling between R4 and V3 (RN). V4 said she went to R4's room and saw V3 outside the room near his medication cart and was yelling at R4 to quit kicking the wall. V4 said R4 was in the sling of the mechanical lift about 4 feet off the ground hovering over his bed. V4 said at the same time another nurse, V6 RN came to the door of the room and asked what was going on. V4 said V3 stated he didn't have time to watch R4 any longer and it was the only way to keep him from getting out of bed.</p> <p>On 7/2/2025 at 10:39 AM, V6 RN said when she came to work on Saturday 6/7/2025, she sat at the nursing station and waited for V3 to come give her report. V6 said she did not see R4 hanging in the mechanical lift and she did not hear V3 yelling at R4 or stating he was using the mechanical lift to control R4.</p> <p>On 7/2/2025 at 11:32 AM, V3 RN said he was new to taking care of R4 and had had a difficult night with him. V3 said R4 would not stay in bed and was up and down all night. V3 said he was attempting to change the linens on R4's bed alone and felt it was easier to use the mechanical lift to raise him up over the bed so the linens could be changed. V3 said he was not using the lift to limit R4's movements but felt this was the safest way to help R4. V3 said he was frustrated when V4 walked past and saw what was going on and he did not communicate properly with V4 that he was just changing the linens and R4 was not being restrained.</p> <p>On 7/2/2025 at 12:31 PM, V1 Administrator said the corporate staff had given V3 a corrective action for failing to follow company policies for conduct, customer service and resident rights. V1 said V3 has resigned from the facility. V1 said V3 was suspended pending the outcome of the investigation and since V3 had admitted he could have done better he was given a corrective action.</p> <p>The facility investigation shows V3 denies he had R4 in the mechanical sling to prevent his movement, he was putting the resident back to bed. V4 stated in the investigation she witnessed R4 being held in the mechanical lift sling and asking the nurse why the resident was being restrained. Text messages from V3 shows his statements were he was waiting for another staff person to help him, he did not put the resident in the sling as a restraint. The text goes on to show he was frustrated but he does not recall saying it was the only way to deal with the resident. V3 also stated in the text he would not argue with the facility and he probably could have something better or safer.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The corrective action form for V3 shows on June 8, 2025 that V2 (Director of Nursing-DON) was informed by a coworker that they witnessed V3 using a sling and mechanical lift to prevent a resident from getting out of bed on June 7,2025. The investigation confirmed that the incident took place as reported, with 2 coworkers also witnessing the use of the hooyer lift. V3 stated that he used the lift to change the bed linens and in a follow-up text message admitted he was not arguing that he could have done something better or safer. The form also shows the conduct policy and it expects the employees to uphold the highest standards of professionalism and ethical practice, ensuring that their actions align with the requirements of their role When providing care, employees must prioritize quality and safety particularly when working with vulnerable residents. The customer service policy was also listed on the report and shows employees should go the extra mile in providing care, showing patience and persistence in [NAME] interaction with residents. The actions obsered in this incident did not demonstrate the expected level and attention to safety for the resident. The resident rights policy referred to in the report shows employees are expected to provide high quality care at all times. Failure to do so will result in corrective action and including termination of employment. R3's own admission that he could have provided better or safer care is considered a violation of this policy.</p> <p>Based on interview and record review, the facility failed to protect 3 residents (R1,R2,R5) from physical abuse by another resident, and failed to protect a resident from abuse by a staff member for 1 resident (R3). These failures apply to 4 of 6 residents reviewed for abuse in the sample of 6.</p> <p>The findings include:</p> <p>1. R1's electronic face sheet printed on 7/2/25 showed R1 has diagnoses including but not limited to Alzheimer's Disease, anxiety disorder, vascular dementia without behaviors, bipolar II disorder, and dementia without behaviors.</p> <p>R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment, behavioral symptoms not direct towards others (pacing, rummaging, verbal/vocal symptoms), rejection of care, wandering, and ambulates independently.</p> <p>R1's care plan with a revision date of 6/26/25 showed, I have a behavior problem and I am an elopement risk (score of 11): pacing, wandering halls, wandering into other resident's rooms and personal spaces .</p> <p>R1's care plan dated 5/30/25 showed, Resident is at moderate risk for abuse/neglect as noted from Abuse screening assessment score of 5 .provide a safe and secure environment.</p> <p>R2's electronic face sheet printed on 7/2/25 showed R2 has diagnoses including but not limited to dementia with agitation, major depressive disorder, and transient cerebral ischemic attack.</p> <p>R2's facility assessment dated [DATE] showed R2 has severe cognitive impairment, ambulates independently, and has physical and verbal behaviors directed towards others.</p> <p>R2's care plan revised on 6/2/25 showed, Wandering into other resident's rooms and personal spaces .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R2's care plan dated 4/21/25 showed, (R2) is/has the potential to be physically and verbally aggressive .If agitation occurs/increases, the resident needs personal space at least arm's length. The resident reacts to touch while agitated.</p> <p>R2's nursing progress note dated 5/28/25 showed, CNA (Certified Nursing Assistant) called nurses station stating she needed this nurse immediately back on (unit), upon entering the unit another resident was on the ground holding her face, CNA stated that (R1) pushed the other resident causing them to fall down and hit their face on the ground. Redirected resident to another area .</p> <p>On 7/2/25 at 12:54PM, V9 (Licensed Practical Nurse-LPN) stated, I was up on (alternate unit) passing medications and V8 (Certified Nursing Assistant-CNA) called and said she needed me back there right away and when I got back there R2 was on the ground holding her head and (V8) said (R1) had pushed (R2) to the ground. (R2) had a laceration on her forehead and some bruising on her knees. I'm not aware of any issues they have had before. Their rooms are right next to each other, so they interact quite a bit. A lot of the residents argue but that's pretty normal on a specialized unit.</p> <p>On 7/3/25 at 11:08AM, V8 (CNA) stated, I had (R1) in the bathroom and she was talking about a man that kept coming in her room the previous night. I knew there hadn't been anyone because I worked the night shift, and nobody was in her room, and she had slept all night. All of a sudden (R2) walked into her room and (R1) started screaming at her to get out of her room and said that was the man that had been in her room. I asked (R2) to leave the room and she did. I took (R1) out to the main area of the unit and when I turned my back, (R1) took her fist and hit (R2) in the shoulder and then pushed her down before I could intervene. (R1) was yelling at (R2) that she stole her clothes, but nothing had happened between them before. (R1) had been getting worse with her behaviors prior to this so we were trying to keep a closer eye on her. Right away I called for the nurse because she was out on the other unit and (R2) was laying on the floor face down and was bleeding. I didn't know what else to do so I tried to keep them separated until the nurse could get there. There is only 1 aide and 1 nurse on the night shift so one of us has to stay on the locked unit while the other one is on the other unit.</p> <p>On 7/2/25 at 1:54PM, V2 (Director of Nursing) stated, We try to keep everyone separated the best that we can if they are having any issues. When we have a whole unit of residents that have dementia it can be challenging some days because some residents have pretty bad days where they are just upset with everyone so you never know what could happen. I do think we tried to keep these residents separated the best that we could, but we can't watch every resident every minute so it's difficult to determine if/when something will happen.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's policy titled, Abuse Prevention and Reporting-Illinois with a revision date of 10/2022 showed, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by .establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment .physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking .</p> <p>2. R2's electronic face sheet printed on 7/2/25 showed R2 has diagnoses including but not limited to dementia with agitation, major depressive disorder, and transient cerebral ischemic attack.</p> <p>R2's facility assessment dated [DATE] showed R2 has severe cognitive impairment, ambulates independently, and has physical and verbal behaviors directed towards others.</p> <p>R2's care plan dated 4/21/25 showed, (R2) is/has the potential to be physically and verbally aggressive .If agitation occurs/increases, the resident needs personal space at least arm's length. The resident reacts to touch while agitated.</p> <p>R3's electronic face sheet printed on 7/2/25 showed R3 has diagnoses including but not limited to dementia without behaviors, dementia with agitation, and anxiety disorder.</p> <p>R3's facility assessment dated [DATE] showed R3 has severe cognitive impairment, has verbal behaviors directed towards others, and ambulates independently with a walker.</p> <p>R3's care plan dated 6/2/25 showed, The resident is/has potential to be physically aggressive related to dementia, history of harm to others related to poor impulse control and invasion of personal area or taking his personal property.</p> <p>R2's nursing progress notes dated 5/30/25 showed, Heard a male resident yelling in the dining room. This nurse had been charting and immediately got up. In the meantime, a CNA was rushing to the dining room and yelling (R3) no, (R3) no. Upon entering dining room, (R2) was seen sitting on the floor with CNA standing on the left side of her. The other resident was standing in front the resident yelling at her. CNA stated she tried to get to (R2) quickly, but the other resident had pushed her to the floor before she could get to her. (R2) has no new injuries. Unable to make out what the other resident was yelling. (R2) was noted to have a trash bag in her left hand. The resident that was yelling was not easily redirected and refused to leave the dining room. (R2) was taken out of the dining room and out of the situation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/2/25 at 10:52AM, V7 (Licensed Practical Nurse-LPN) stated, I heard the incident, it happened in the dining room. There was a CNA (V10) in the day room, and we heard (R3) yelling loudly and I hurried and got up and went in there with the (V10). (R2) was sitting on the floor in front of (R3) and he was yelling at her. Neither of them could recall what happened but it's pretty obvious that he pushed her down. The aide stepped in and took (R3) to sit down as he refused to leave the dining room. I examined (R2) while she was on the floor and then took her down to her room for a more thorough assessment. She had no injuries or bruising. She was her norm after the incident. (R3) has been fine since then and we have had no further incidents with him.</p> <p>Several attempts were made on 7/2/25 and 7/3/25 to interview V10 without success; however, V10 provided a statement to the facility on 6/2/25 showing, I witnessed the incident between (R2 and R3). I heard (R3) yelling and following (R2) around the dining room. He was mad because she was carrying a gross garbage bag around. Before I could get to them, he pushed her down.</p>		